Cluster Evaluation of the Community-Based Public Health Initative funded by the W. K. Kellogg Foundation

1993 ANNUAL REPORT

University of Minnesota
Center for Urban and Regional Affairs
Minneapolis, Minnesota

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Connie C. Schmitz

The CBPH at a Glance

The Community-Based Public Health initiative was designed to "assist communities, academic public health programs, and local health agencies to develop joint models for community-based education, research, and service." Grants were awarded in 1992 to seven consortia in the U. S.

Time Period:
1991 - 92 Phase I Leadership and Model Development
1992 - 93 Phase II Implementation *(October 1, 1992, start date)*

Program Directors:
Dr. Thomas A. Bruce and Dr. Steven Uranga McKane

Cluster Evaluation Team:
University of Minnesota, Center for Urban & Regional Affairs
Dr. Constance C. Schmitz, Principal Investigator
Consultants: Ms. Carol McGee Johnson, Ms. Diane Morehouse, Dr. Mary Odell Butler, and Dr. Abraham Wandersman
Assistants: Ms. Cecilia Goetz, Ms. Carolyn Link Carlson
Subcontracts: Minnesota Center for Survey Research
U of M Media Resources Department

Funded Consortia:
Massachusetts, North Carolina, California, Washington, Maryland, Michigan, Georgia

Organizations Involved:
Academic: N = 25
Public Health Practice: N = 23
Community: N = 31

Number of Participants:
Approximately 290 members are active in the seven consortia.

Fiscal Agents & Budgets:

$1,087,500.	University of Massachusetts, Amherst, &
+1,162,500.	Berkshire Area Health Education Center,
2,250,000.	Pittsfield, MA
2,250,000.	University of North Carolina, Chapel Hill, NC
2,057,112.	Alameda Health Consortium, Oakland, CA
2,007,493.	Group Health Cooperative of Puget Sound, Seattle, WA
1,260,711.	Johns Hopkins University, Baltimore, and
+731,515.	Clergy United for the Renewal of East
1,992,226.	Baltimore, MD
1,958,273.	University of Michigan, Ann Arbor, MI
1,416,830.	Cobb County Board of Health, Marietta, GA

Blanket Approriation:
1,916,908. (Includes $981,908. for Cluster Evaluation)

Cluster Evaluation of the
Community-Based Public Health Initiative
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Table of Contents

Executive Summary

Introduction

This Executive Summary will briefly describe the first year of the CBPH Cluster Evaluation: its purpose, stakeholders, goals, process, and activities. Next it will summarize our knowledge of consortia development and project-level evaluation, and our impressions of CBPH progress as a whole. We conclude by outlining Cluster Evaluation challenges and goals for the second year. Many of the supporting details for this text (e.g., calendars, agendas, site visit protocols, reports) are contained in the Appendix.

Overview of the Cluster Evaluation's First Year

Purpose

The CBPH Cluster Evaluation (CE) team began the year by working with WKKF program directors to clarify the purposes of the CE. In early fall, 1992, we determined the CE needed to:

1. **Gather information** about the CBPH that has the potential to:

   a) reform the way that public health service agencies work with their communities to improve the lives of people;

   b) reform the way that communities address their health needs;

   c) reform the way that academic institutions prepare their students for public health practice.

2. **Increase the likelihood of a successful CBPH** initiative by supporting project-level evaluators, facilitating dialogue with WKKF, and providing feedback.

3. **Gather information** about the CBPH that has the potential to inform programming and grantmaking policies at WKKF.

We have continued to pursue these purposes throughout the year, placing greatest emphasis on the number one purpose.

Stakeholders

In keeping with these purposes, we identified the stakeholders involved with the CBPH. In our early discussions with WKKF program directors, we believed the stakeholders to be:

- **External policy makers and influential leaders** in relevant constituencies, such as regional and local public health offices, professional organizations (e.g., NACHO, USCLH, APHA , ASPH), accrediting agencies, and community groups (e.g., Urban League)

- **CBPH consortia members** (e.g., project directors, governing bodies, CEOs)

- **WKKF** program directors and board members

As the year progressed, we came to feel that consortia members and WKKF program directors were our most important *stakeholders,* because: (a) they are significantly invested in the CBPH, (b) they are actively involved with its development, and (c) they will be directly affected by its success or limitations. External policy makers, in contrast, are not so invested, involved, or affected. We do consider this external group, however, our *primary audience* for CE findings.

Goals

Our overall goal for the year has been to develop both the relationships and the organizational structure needed for carrying out the work of the CE. One of our first, and most important tasks has been that of getting to know the seven consortia in the CBPH and to understand their objectives, intended activities, organizational structures, and membership. This goal went hand in hand with that of developing a deeper understanding of the Foundation's expectations of the CBPH and CE. As the year progressed, we worked towards developing an "evaluation blueprint" -- a work plan that identifies important evaluation questions, clarifies the distinction between cluster-level and project-level evaluation, outlines the areas of common data collection or collaborative research, and organizes data collection strategies.

Process

In developing the evaluation blueprint (see Appendix) we used a modified stakeholder process. Figure 1 on the next page illustrates this process, which integrated information from three sources to generate guiding evaluation questions for the CE. These sources were:

1) **The Foundation**, as we understood their goals for the CBPH and questions of the CE through meetings, letters, documents, and feedback to blueprint drafts;

2) **Consortia members**, as we understood their CBPH models and questions of the CE through site visits, meetings, documents, and feedback to blueprint drafts;

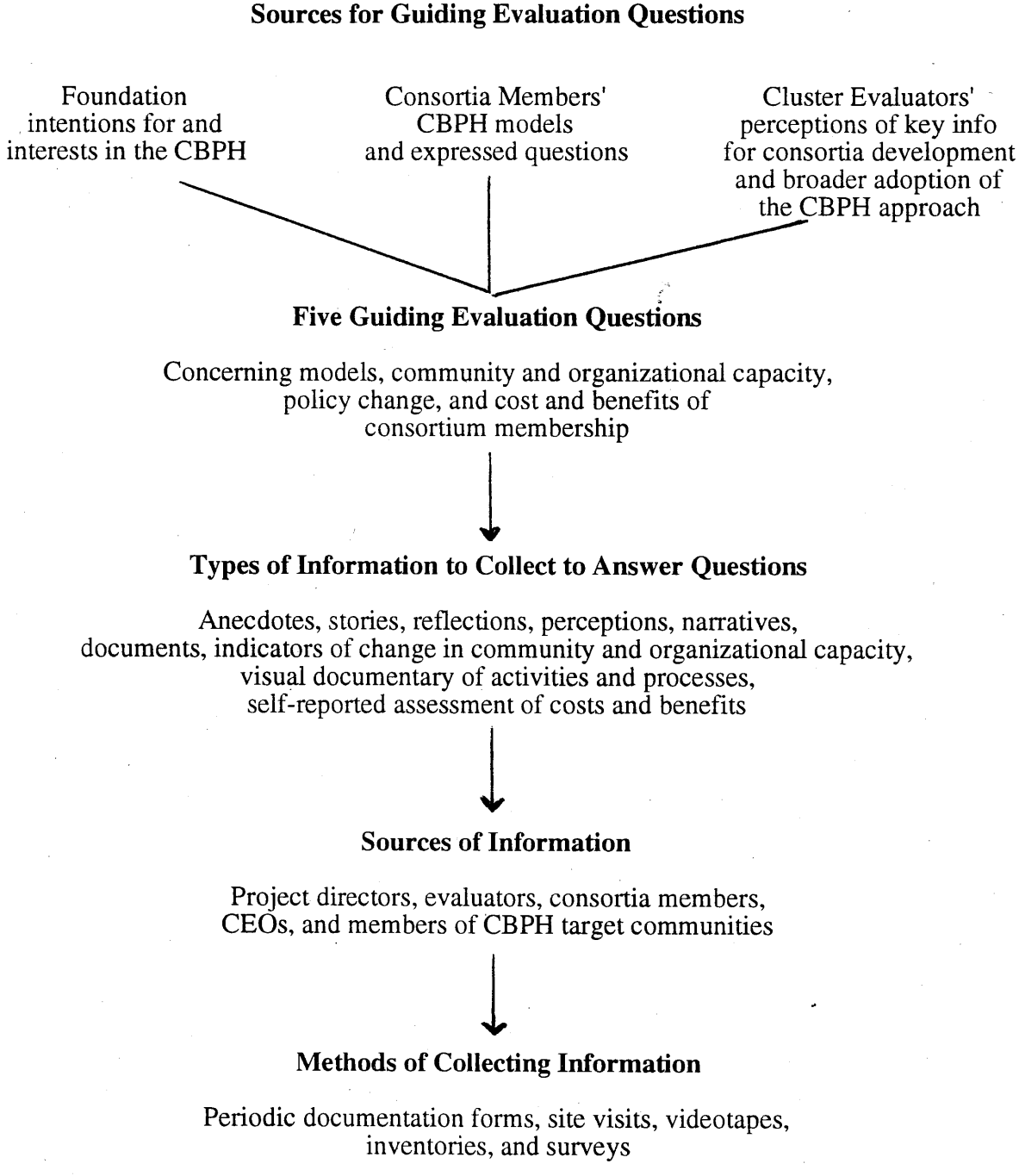
3) **Our own analysis** of what needed to be studied, based on site visits, discussions, reading, and the working papers of consultant Abe Wandersman. Our analysis also tried to take into account what we believe external audiences would want to know about the CBPH in order to adopt a similar, community-based philosophy or approach.

The evaluation blueprint has gone through multiple drafts. The first was mapped out after the initial meeting with Foundation program directors in early fall of 1992. Successive drafts were prepared both before and after the Evaluation Networking Conference in April, which was attended by project directors and project evaluators. Further drafts were made after this same group met at the end of the CBPH Annual Meeting in June. The current evaluation blueprint was completed August, 1993.

We are now at the point of confirming the details of the blueprint, having gained consensus with stakeholders regarding the evaluation questions. During September, 1993, a round of individual and group conference telephone calls with project evaluators has been scheduled. We will be seeking their input on the specific indicators we want collected at each consortium site, so that we can aggregate the information at the CE level. We will also talk with them about collaborating around the task of defining and measuring "community empowerment."

Figure 1

Cluster Evaluation Model for the CBPH



Activities

To full CE purposes we engaged in several activities this year (see Appendix). Highlights from the year include:

- **Three-day site visits** to each CBPH consortium. These visits included meetings with consortium partners, CEOs, de-briefing sessions with governing bodies, and written reports.

- **Two working papers** developed by an external consultant, entitled: *"Characteristics of Viable Organizations,"* and *"Understanding Coalitions and How They Operate."*

- **Development of a membership data base** and creation of **organizational "maps,"** depicting governing bodies for each consortium.

- **The evaluation networking conference**, in which CE team members facilitated the sharing of consortia progress in evaluation, and presented sessions on topics such as: community empowerment; a framework for understanding coalition development; clarifying guiding evaluation questions; and a process for identifying common indicators.

- **The follow-up survey of 1991-92 Leadership and Model Development (LMD) participants.** This survey examines how participants feelings' about the LMD have changed over time, and how funded and non-funded respondents differed in terms of activities occuring after the LMD. The report includes suggestions for revising the LMD program as a model for grant making.

- **The "videotape project,"** a collaboration with consortia around the making of a film documentary about the CBPH. This project led to the Videotape Workshop, which was attended by 13 videographers from the seven consortia.

Our Current View of the CBPH

Consortium Development

Consortia are working hard, developing slowly, but for the most part, well on their way towards establishing the organizational structures and relationships needed to proceed with their work. Some specific observations:

- **CBPH consortia are not simple partnerships** between three easily defined or distinct groups. Rather, they are very complex networks of multiple, diverse stakeholders, varying in size, levels of organization, and geographic spread (see tables in the Appendix).

- **Complexity is one perhaps one reason why consortia have had to devote much of their time and energy this year to internal governance and organization.** Different models of organization and governance are being developed. While most embrace a consensus philosophy of decision making and non-hierarchical structure, sheer size has meant some form of representation has been necessary. The more successful consortia appear to have elaborate structures and systems of communication. Only three of the seven have identified project directors at the consortium level (North Carolina, Massachusetts, and California).

- **Making the transition from the LMD year to the first year of implementation meant growing pains** for many consortia, as they doubled in size, dealt with the "second generation" of participants, and learned that the goals of the CBPH were not always easy to explain to newcomers.

- **The start-up of these projects appears to have been slowed by the budget reductions** which occurred during the award negotiation process. Expecting much larger awards, virtually all seven consortia had to redesign their proposed model and renegotiate budgets amongst themselves once the actual award was received. According to some consortia, this process was quite painful and time consuming.

- **Some consortia were more successful than others at creating a unified mission**, or "marriage of purpose" out what began (in most cases) as a "marriage of convenience." Some consortia are building on already established personal relationships between members, but most are working together as a collaborative for the first time. Disagreement over goals, priorities, and processes have been "par for the course."

- **Implementation activities appear to be occuring mostly in the academic and community domains**, according to the Survey of LMD Participants and observations we gained during site visits. Course revision, curriculum planning, increased field experiences for students, increased visibility and leadership for some community members, needs assessments, training for community health workers, career clubs, health education/promotion, and various other community projects are the most frequent types of activities reported.

- **The degree of collaboration occurring varies.** While many people talk about collaboration, there may be less actual collaboration (i.e., joint investment of resources, co-leadership, dividing up job responsibilities) than sharing of ideas and opinions, followed by separately owned and managed projects.

- **Policy change remains an important but elusive goal.** As with "collaboration," "policy change" was a frequently voiced aim, but it's unclear which policies consortia are targeting for change. Some consortia have brought policy makers into the picture by placing them on their governing boards, or using them as advisors; most have not.

Status of Project Evaluation

Project evaluation is proceeding slowly. This is partly because evaluation generally took a hefty cut during budget negotiations. Selecting an evaluator has proved a delicate task for political as well as philosophical reasons. Conflicts have arisen over things such as the purpose of evaluation, the approach to use, type of person to hire, where the evaluator should be located or "positioned" (i.e., internal to consortium or external), and to whom the evaluator should report. In one case, the autonomy of teams within the consortium led to the hiring of two different evaluators, conducting what may become separate evaluations. Evaluators came on board at varying times during the year (see Table X in the Appendix). A few evaluators were identified during the LMD, but these people are generally functioning in dual roles, and it's unclear how much time they've been able to put into evaluation.

Evaluators are coming to the CBPH with varying degrees of training and experience. All had questions about the role they were expected to play within the consortium and the relationship they were to have with the CE team. By mid-year, some of the more

experienced evaluators were questioning the extent to which they should be expected to collaborate with the CE team on "CE tasks." By June, the majority seemed to feel that CE tasks did concern them, and were very interested in standardizing data collection when possible and collaborating on the work of defining and measuring "community empowerment."

Summary of CBPH Strengths and Challenges

Strengths

- Heavy investment in terms of time and psychic resources on the part of many consortia members
- Visible efforts to broaden consortia membership have been made
- Strong commitment to the concepts of community-based public health and community empowerment
- Visible progress in most consortia in developing an organizational structure and culture for work
- Visible progress in some consortia in implementing innovative and important activities
- Growing willingness to collaborate in Cluster Evaluation activities

Challenges

- Insufficient funding, combined with shrinking resources in academic institutions and public health agencies
- Difficult, diffuse, and sometimes conflicting goals
- Complexity of consortia makes management difficult and calls for exceptional leadership
- Political constraints in academic, public health practice, and community environments
- Inability of some consortia to transcend past poor relationships, or develop sufficient trust to proceed

Cluster Evaluation Plans for Year 2

Challenges

Two important challenges we encountered this year had to do with (a) implementing a stakeholder-based model of evaluation and (b) clarifying appropriate outcomes for the CBPH. These challenges are described below.

a) In a stakeholder model, evaluators try to identify leaders of invested groups to draw into the work of the evaluation. These people both communicate the interests and questions of the groups they represent to the evaluators, as well as translate evaluation tasks and findings back to their constituencies. This approach seemed well suited to the CBPH, which emphasizes grass-roots change and respect for all partners in a collaborative process of problem-solving and change.

   While project directors and evaluators seemed to be the logical representatives for us to turn to, not all CBPH consortia decided to elect a central project director. In other consortia, governance is happening at multiple levels (consortium and subcoalition), or not yet happening. Many diverse groups at the table make representation and the relay of information slow to occur. These facts, combined with the length of time it's taken for project directors and evaluators to come on board, the different levels of training and time commitment across evaluators, and insufficient meeting time in our timeline, made it difficult to follow a "true" stakeholder model. As the year progressed, the CE team played a more directive than facilitative role.

b) During the LMD, the CBPH introduced some powerful ideas: collaboration, systems reform, policy change, community ownership and empowerment. The goals of the initiative have always been broad and ambitious. In translating these goals into more specific objectives and activites, most consortia encountered difficulties. Is community empowerment the end result, or the vehical for affecting change in universities and agencies? Can goals in all three arenas be pursued simultaneously, or does pursuit of one happen at the expense of another? What actual aspects of the systems are to be changed--can be changed? Which policies should be addressed? It's safe to say, no two consortia interpret the goals of the CBPH in exactly the same way.

   Focusing the Cluster Evaluation on CBPH outcomes has therefore been difficult. Writing the evaluation blueprint's "expected outcomes" was an enormously useful exercise (especially for Questions #2 and #3), in that it brought the issue of specific goals and outcomes to a head. We feel the blueprint does a good job in laying out a range of possible outcomes for the CBPH. Still, the list can and should be improved through further dialogue with the Foundation and with project evaluators. (We feel public health practice goals are somehwat vague, as is capacity building at the community level.) In year 2, we will turn our attention to helping consortia clarify and develop consensus around the goals they are pursuing.

<u>Year 2 Goals for the CE</u>

Given these challenges and the needs of this work, we have outlined the following goals for the coming year:

1 **Continue to strengthen working relationships with project evaluators and directors.** Use project evaluators as key contact persons for issues relating to the Cluster Evaluation. Use project directors as key contact persons for site visit arrangements and videotaping issues.

2 **Achieve consensus on which indicators to track across consortia, and how.**

3 **Achieve consensus on areas of further collaboration** (i.e., define and measure "community capacity") with project evaluators.

4 **Implement the evaluation blueprint,** i.e.:

- Conduct seven extended site visits, with local videotaping.
- Develop separate goal agreement inventories to administer to consortia. Feedback inventory findings to individual consortia.
- Build documentation forms for monitoring common indicators. Collect and report data from year 2.
- Develop a survey weighing the costs and benefits of consortium membership.
- Compile a videotape documentary of the CBPH in its second year.

Issues for Foundation Program Staff

- **Consider the recommendations provided in the 1993 Survey of Leadership and Model Development Participants** if further use of the LMD, as a model of grant making, is expected (see Executive Summary of this study in the Appendix).
- **Regarding evaluators, consider mandating that all future projects in cluster intiatives** assign a 50% time evaluator to their staff; that this person be external to the consortium or project team; and that the evaluation budget should, at a minimum, run between 5% - 10% of the total grant award. Do not fund projects that fail to provide this.

While it is too early to predict what characteristics are important to look at when funding cluster projects, some early hypotheses about potentially important criteria are listed below:

- **Length and quality of previous working relationships** between organizations involved with a consortium seems to be making a difference with how well consortia are functioning in this first year.
- **Having a unified, central place and community** (in contrast to geographic spread and multiple unrelated communities) appears to be impacting working relationships in this first year, and may predict long term health for a consortium.
- **The benefits of belonging to a consortium will have to outweigh the costs (which we know can be significant) for these groups to survive.** The consortia with the greatest chance of survival are those whose leadership can moderate the costs and benefits so as to keep participation and recruitment high. The Foundation can continue to be attentive to the costs reported by consortia participants -- be they fiscal, political, or emotional -- and to brainstorm strategies for keeping the balance tilted in the right direction.

In conclusion, Year 1 has been an enormously busy year for consortia and the CE team. We look forward to learning more as we move ahead into Year 2.

Appendix

Tables Summarizing CBPH Consortia

Year I

Calendar of Year I Cluster Evaluation Activities
Organizational Maps
1993 Evaluation Networking Conference Agenda
Participant Evaluation of the 1993 Evaluation Networking Conference
Videotape Workshop Agenda
1993 Survey of 1991-92 Participants in the Leadership and Model Development Program
Themes from Year I Site Visits

Year 2

Calendar for Year 2 Cluster Evaluation Activities
Evaluation Blueprint
Year 2 Site Visit Protocol

Table 1

Organizations Involved in CBPH Consortia

Entity	CA	GA	MD	MA	MI	NC	WA	Total
				(frequencies)				
Schools of...								
Pub. Health	1	1	1	1	1	1	1	**7**
Nursing			1				1	**2**
Medicine		1	1	1				**3**
Soc. Work					2		1	**3**
Health Sci.					2			**2**
Community Colleges					1		2	**3**
AHEC				1		1		**2**
Public Schools	1		1		1			**3**
County Pub. Health	1	1			1	4	2	**9**
City Pub. Health			1		1			**2**
Health Board		1		1			1	**3**
Neigh'bhd Providers	2		1		1	1	3	**8**
HMO							1	**1**
Park & Rec							2	**2**
Church	1		1		1			**3**
Cm'ty. Action Agencies	1		1	4	1	1		**8**
Other	7	3			5	2	1	**18**

Table 2

Target Communities Involved with CBPH Consortia

Consortium	Number of Communities	Ethnic Group(s)	Locale
Maryland	1	African American	Urban
California	1	Multicultural	Urban
Michigan	2	African American	Urban
Washington	2	Native American and Multicultural	Rural, urban
Massachusetts	4	Latino and Causasian	Urban, rural
North Carolina	4	African American	Urban, rural
Georgia	3	African American	Urban, suburban

Table 3

Geographic Spread of CBPH Consortia Sites

Consortium	No. of Geographic Sites	Geographic Spread
North Carolina	4	Across major portion of state
Massachusetts	4	" " " "
Washington	2	Across major portion of state
Georgia	3	Greater metropolitan and regional
Michigan	3	
California	1	Consolidated within city
Maryland	1	" " "

Table 4

Representation on CBPH Governance Boards

Consortium	Representation on Governance Board
Maryland	Separate academic and community councils
Washington Massachusetts	All partners and members represented " " " "
North Carolina Michigan	18 - 24 member boards, equal representation from each constituent group
California Georgia	Community majority " "

Table 5

Size of Governance Bodies at the Consortium and Sub-Consortium Levels

Consortium	Consortium Governance	Number of Members	Sub-consortium Governance	Number of Members
California	Governing Board	21	None	
Georgia	Board of Stewards	12	Rose Garden Hills	5*
			University/John Hope	15*
			Kennesaw Village	3*
Maryland	Steering Committee	14	Univ. Exec. Committee	13
			Com'ty. Exec. Committee	8
Massachusetts	Governing Board	16	Worcester Coalition	18*
			Holyoke Coalition	12*
			Athol Orange	12*
			Northern Berkshires	12*
Michigan	Collaborating Group	24	University Team	9
			Detroit Team	10
			Genesee County Team	10
North Carolina	Steering Committee	21	Chatham County	9
			Lee County	5
			Orange County	10
			Wake County	15

* Denotes estimate based on site visit experience

Table 6

Leadership of CBPH Consortia

Consortium	Fiscal Agent(s)	Head of Consortium Governing Body	General Project Leadership Role
North Carolina	University	Rotating community and health department	University consortium members
Maryland	Community University	None (unclear?)	Separate community and university PDs, both consortium members
Washington	HMO	None (unclear?)	HMO (interim)
Massachusetts	University AHEC	AHEC/Community	Professional external PD
Michigan	University	None	Separate university, public health, and com'ty PDs, consortium members
Georgia	County Health Board	Community	Unclear, has changed during year
California	Community	Community	Professional external PD

Table 7

Decision-Making Methods of CBPH Consortis

Consortium	Decision-Making Model	Decision-Making Formality
Massachusetts California	Consensus "	Formal "
Washington Michigan	Consensus "	Informal "
North Carolina Georgia	Voting, majority rule "	Formal "
Maryland	Unclear	Unclear

Table 8

Number of CBPH Consortia Members by Constituency, Ethnicity and Gender, and Consortium

Constituency

Academic		107
Health Practice		61
Community		86
CBO	62	
Citizen	13	
CBO/Citizen	11	
Other		15

Ethnicity and Gender

African American	80	28%
Asian American	3	
Hispanic/Latino/Chicano	5	
Native American Indian	10	
Caucasian	94	33%
Other	4	
Not identified	88	31%
Female	139	49%
Male	112	
Not identified	33	12%

Consortium

California	31
Georgia	36
Massachusetts	29
Maryland	55
Michigan	46
North Carolina	50
Washington	37

TOTAL MEMBERS **284**

Data are based on Individual Memberships Forms returned to the CE staff in spring of 1993.

Table 9

Profile of Project-Level Evaluators and Their Budgets

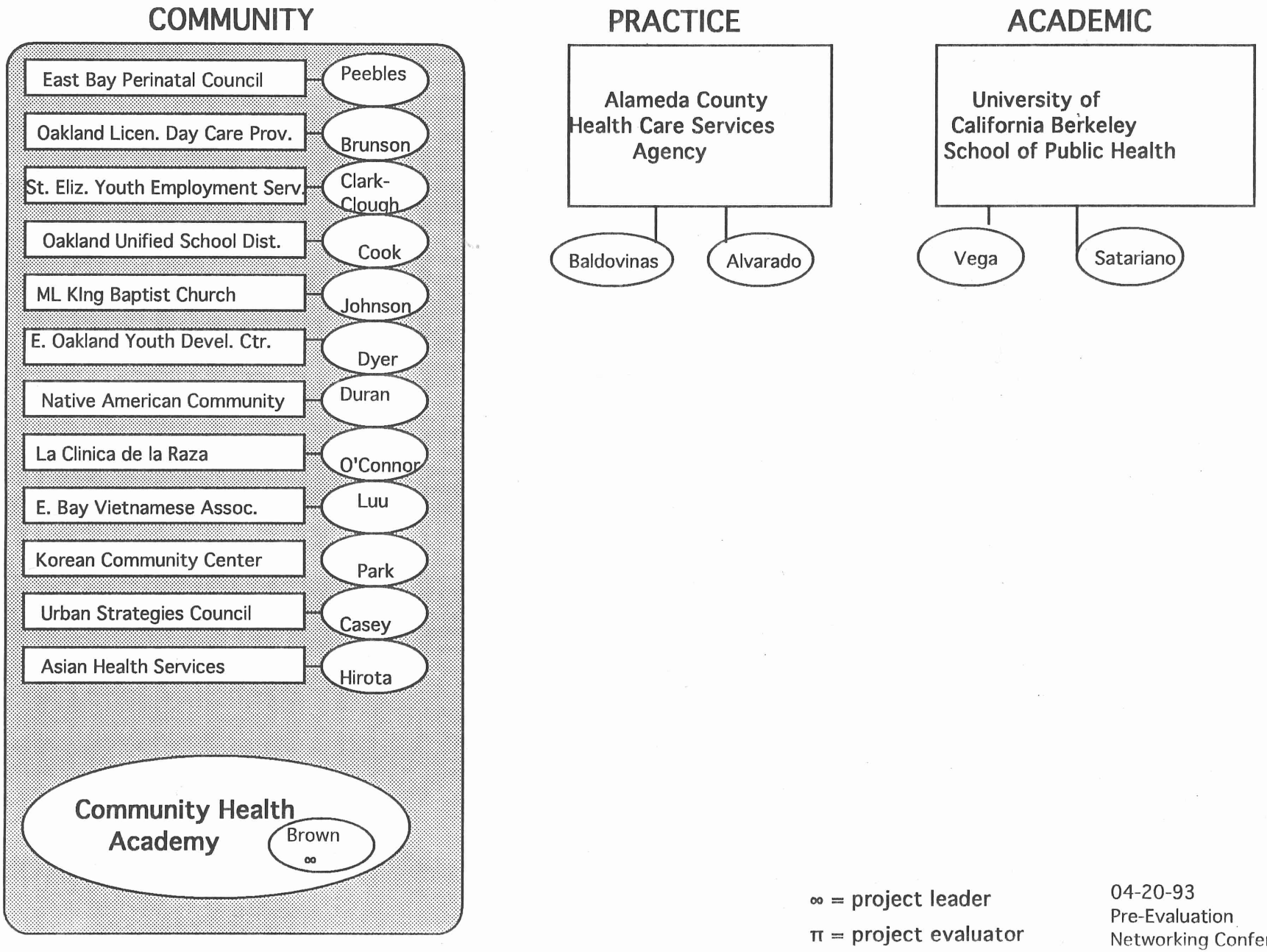
Consortium	% Time	Position Type	When Hired	Year 1 Eval Budget	Total Eval Budget
Maryland					
L. Bone	20%	Internal; also project director	LMD	Not a line item	Not Known
M. Hill	10%	Internal; also on consortium	LMD	"	"
Georgia					
R. Braithwaite	20%	Internal; also on consortium	LMD	$10,000.	$70,000.
California					
M. Servin	50%?	External consultant	Aug '93	$12,500.	$87,000.
North Carolina					
E. Parker	50%	GRA Univ	Jan '93	0.	$160,000.
A. Cross	0%	Supervisor	LMD	"	"
Washington					
?	50% - 75%	External consultant	To be hired	$34,375.	$184,375.
Massachusetts					
E. Denny	?%	External consultant	July '93 (interim)	$8,250.	$105,000.
Michigan					
A. Schulz	50%	External U. staff	Apr '93	$12,000.	$72,000.
E. Massie	20%	External	LMD	$12,000.	$42,000.

Calendar For Year One
Cluster Evaluation Activities
1992-1993

'92- '93	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
WKKF Meeting		10/7 Mpls				2/24 Mpls				6/1 BC		
APHA Meeting			11/9 Wash DC									
Site Visits			11/23 GA	12/7 MD 12/14 WA	1/19 NC 1/25 MA	2/15 CA	3/2 MI					
Project Directors Meeting					1/14 Tusc							
Data Collection for Individual Data Base								4/30				
Evaluation Networking Conference								4/27 Mpls				
Background Papers							3/15	4/1				
CBPH Annual Meeting										6/28 Ann Arbor		
Follow-up Survey of LMD Participants									5/21 Survey sent out			8/31 Report
Videotape Workshop											7/15 Mpls	

CALIFORNIA

16 Member Governing Board + 1 ex-officio Project Director. Based on 1/93 Gov. Board list.



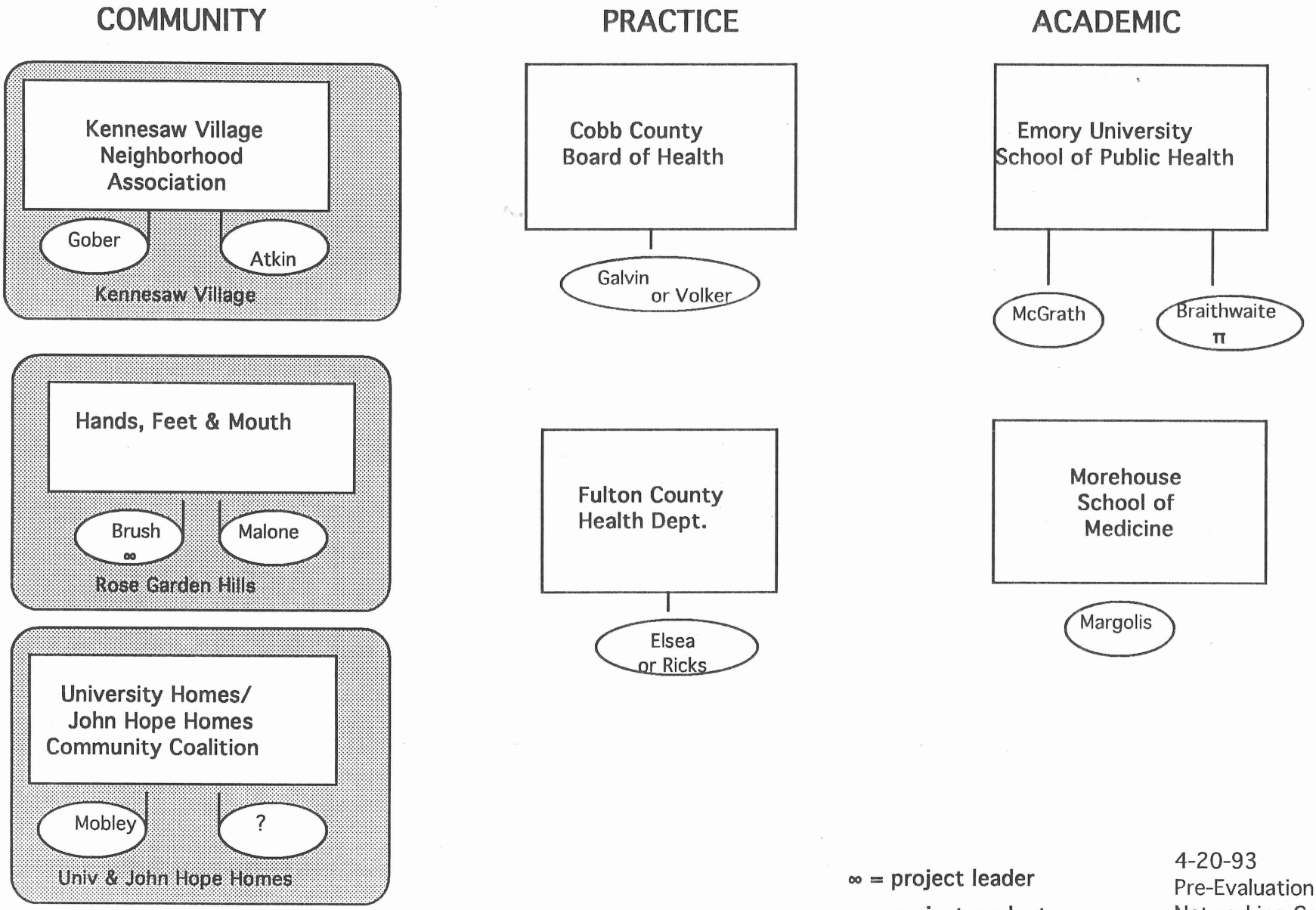
∞ = project leader

π = project evaluator

04-20-93
Pre-Evaluation
Networking Conference

GEORGIA

10 Member Board of Stewards + 1 Ex-Officio Evaluator. Based on Cluster Evaluation site visit notes



∞ = project leader

π = project evaluator

4-20-93
Pre-Evaluation
Networking Conference

MARYLAND

COMMUNITY

(Community Committee)

- Clergy United for the Renewal of East Baltimore
  - Prentice
- Heart, Body & Soul
  - Tuggle
  - Scott ∞
- Community-University Liason
  - Becker

PRACTICE

- Baltimore City Health Dept.
  - Dorsey
  - Beilenson
- Health Care for the Homeless
  - Gaines
  - Gillis

ACADEMIC

(School Curriculum Commitee)

- Johns Hopkins University
  - School of Public Health
    - Bone π
    - Zeger
  - School of Medicine
    - Levine
  - School of Nursing
    - Hill
- Baltimore Public School System
  - Caples
  - Waters

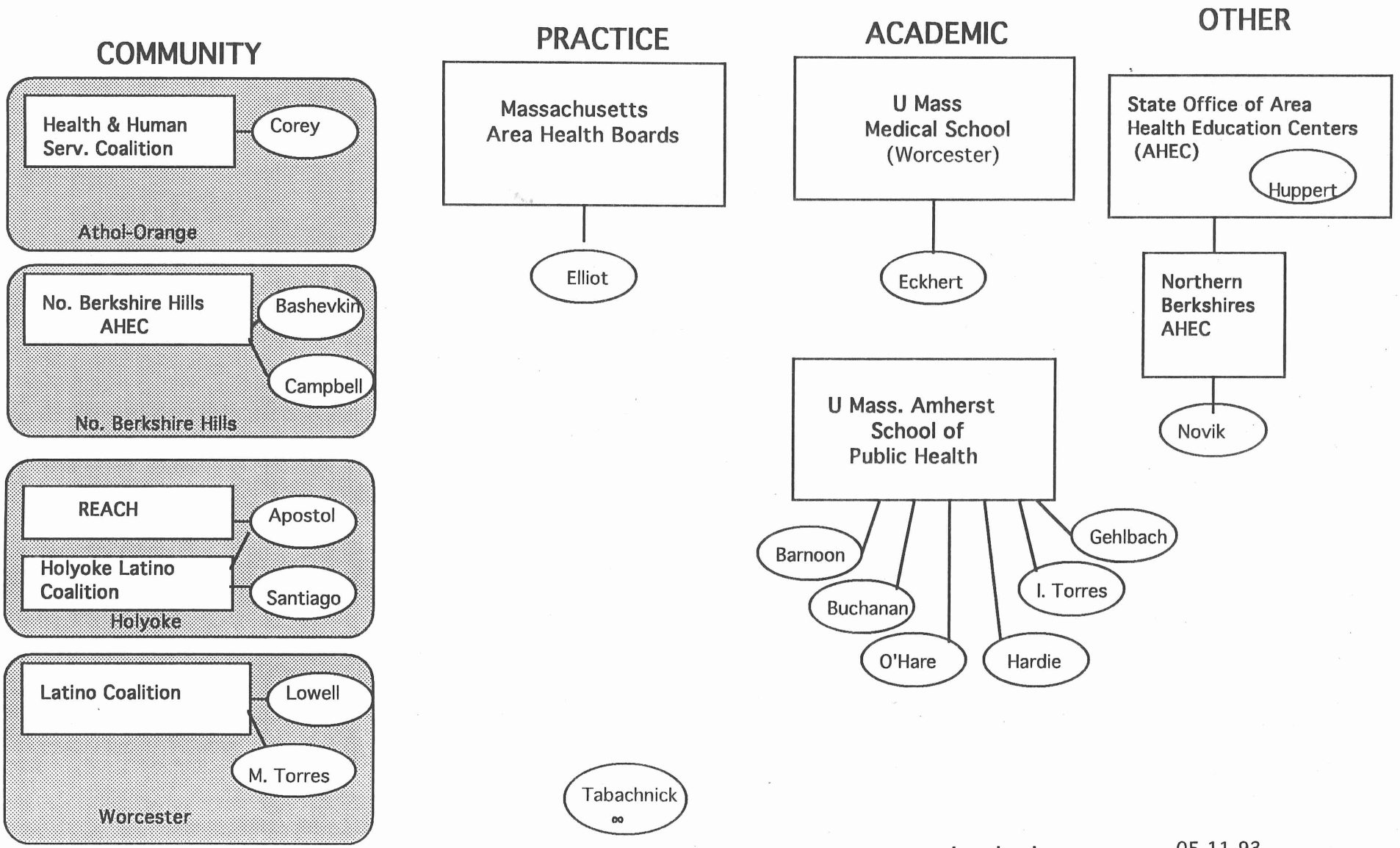
∞ = project leader/ community coordinator

π = project evaluator

05-25-93
POST-Evaluation
Networking Conference

MASSACHUSETTS

17 Member Governing Board + Project Director. Based on 1/21/93 membership list.



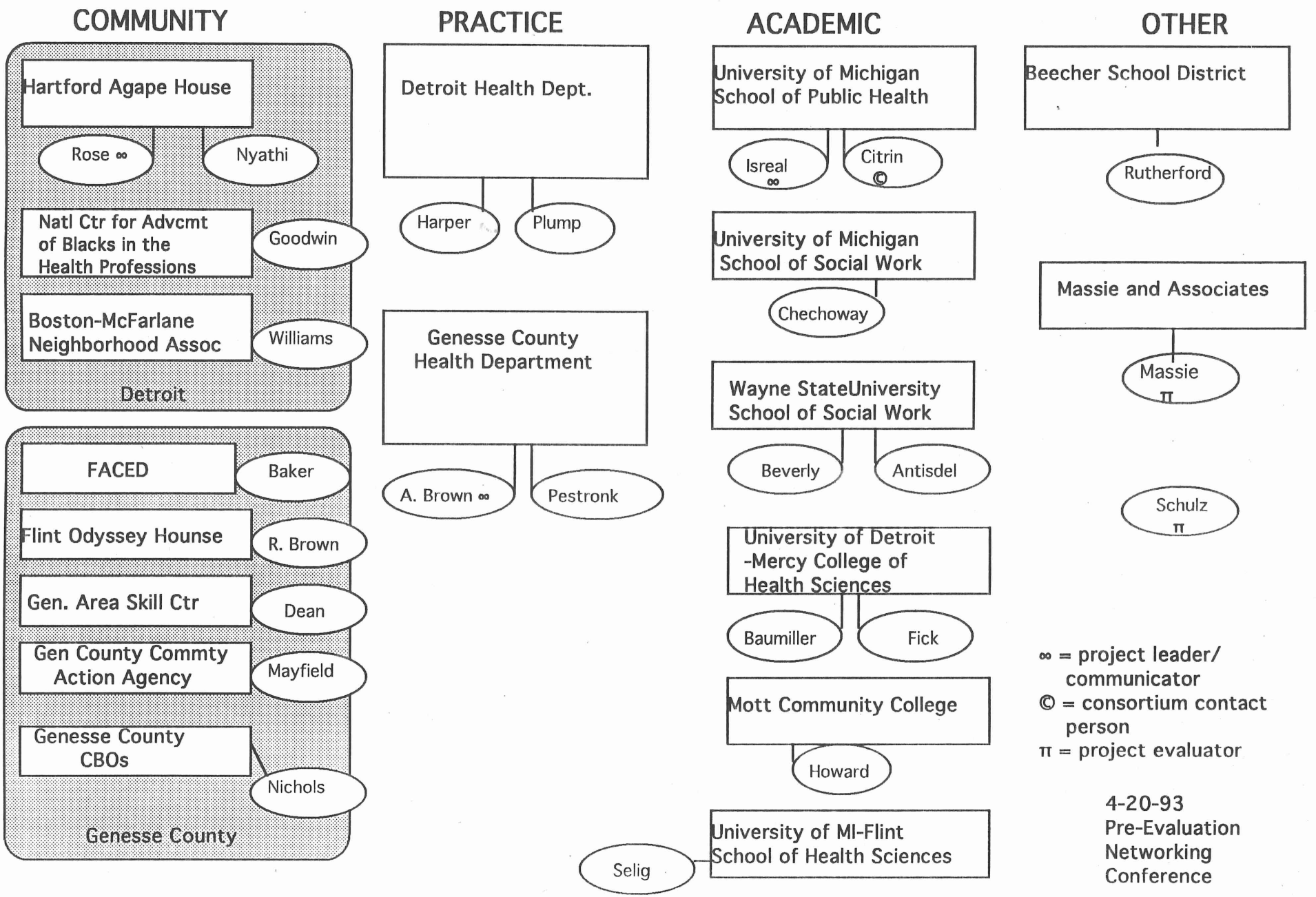
∞ = project leader

π = project evaluator

05-11-93
POST-Evaluation
Networking Conference

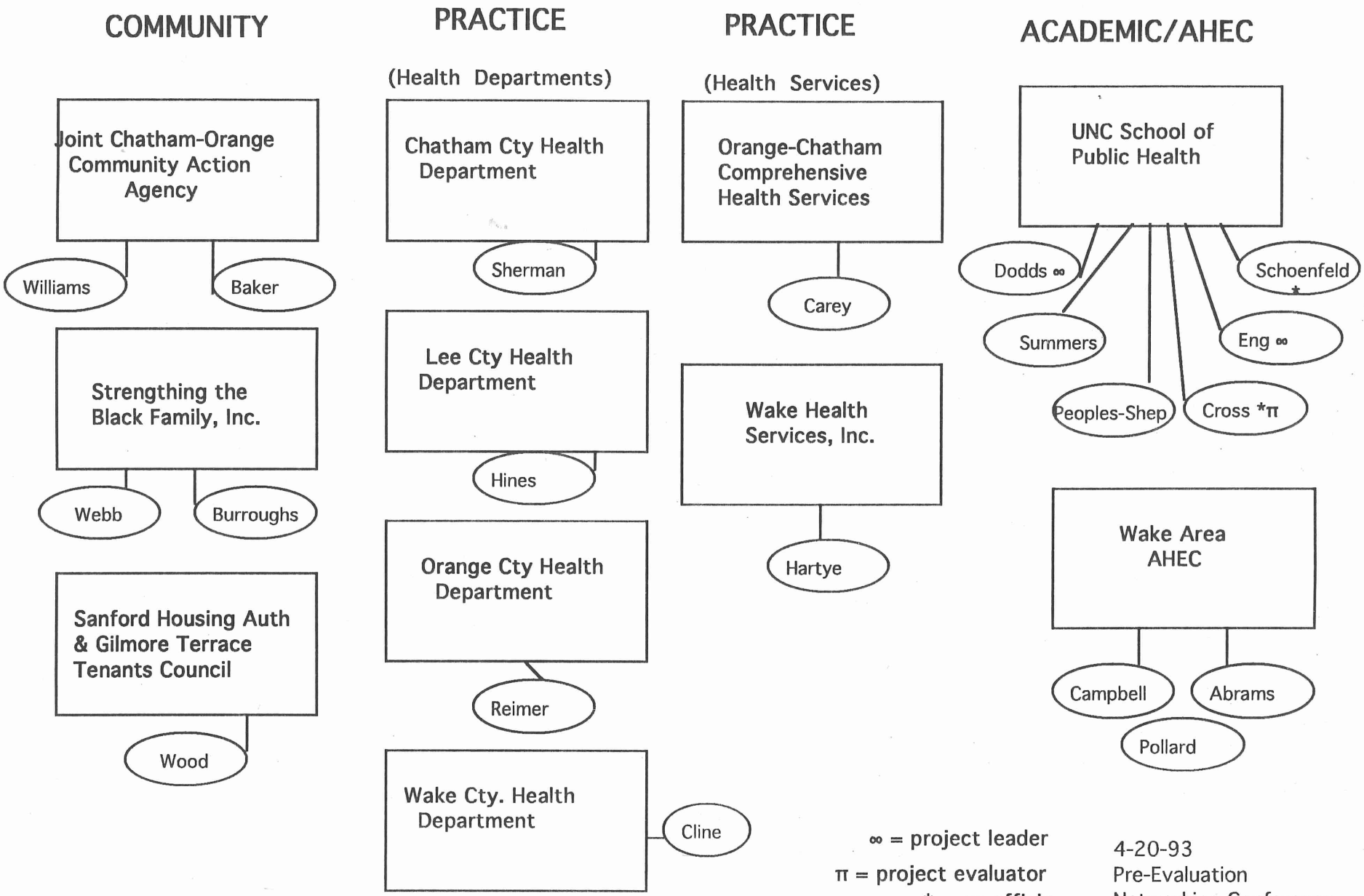
MICHIGAN

24 Member Collaborating Group. Based on 3/1/93 Colaborating Group Meeting List.



NORTH CAROLINA

18 Member Steering Committee. Based on 4/7/93 Steering Committee List

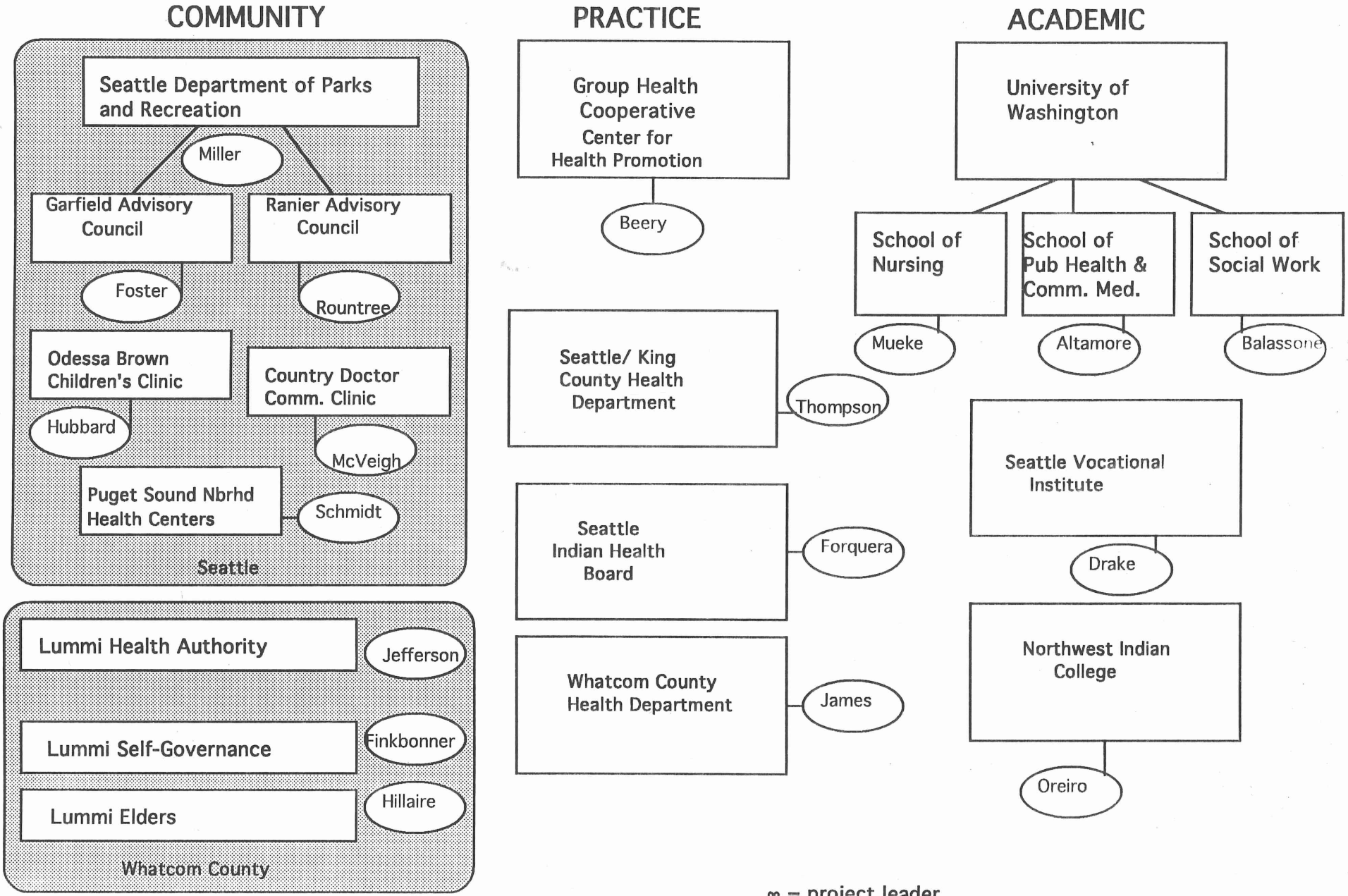


∞ = project leader
π = project evaluator
* = ex-officio

4-20-93
Pre-Evaluation
Networking Conference

WASHINGTON

18 Member Governance Council: Based on 12/92 Master List



∞ = project leader

π = project evaluator

4-20-93 Pre-Evaluation Networking Conference

Evaluation Networking Conference
WKKF Community-Based Public Health Initiative
April 27-29, 1993

Minneapolis, Minnesota

Audience: CBPH Consortia Project Directors and Evaluators

Main Topic: Evaluation of the CBPH Initiative at the Cluster and Consortium Levels

Goals: 1) To support consortia as they develop plans for evaluation

2) To further the cluster evaluation process

Objectives:

We hope that participants will leave the conference with . . .

- A clearer idea of what they want to accomplish through consortium evaluation, and how to do it.
- A better understanding of what the Foundation and the Cluster Evaluation team hope to accomplish through evaluation.

To address these outcomes, we will moderate sessions and activities that provide participants with an opportunity to:

- Hear how other CBPH consortia are approaching their evaluations; share challenges and strategies.
- Dialogue with the Foundation about its expectations of consortium evaluation.
- Dialogue with the CE team about cluster evaluation activities and consortia members' role in those activities.
- Think about "community empowerment" and how to define, recognize, and evaluate it as part of the CBPH.
- Learn about some current evaluation approaches being used with other partnership initiatives.
- Get feedback (if desired) on their ideas and plans for evaluation from Cluster Evaluation team members, guests, and others attending the Conference.

As cluster evaluators, we hope to leave the conference with . . .

- A better understanding of where consortia are in terms of evaluation; what their concerns and questions are; and what their future needs from us might be.
- Feedback on our guiding evaluation questions and cluster evaluation strategies.

Tuesday Evening

5:30 RECEPTION *at the Radisson Metrodome Hotel, University of Minnesota campus (east bank), in the foyer next to the Regents Room., second floor*

6:30 DINNER *in the Regents Room.*

PROGRAM *in the Regents Room.*

7:30 Thomas A. Bruce -- W. K. Kellogg Foundation Program Director for CBPH.

- Welcome
- The Community-Based Public Health Initiative: Origins and Goals for Evaluation
- Questions and discussion

8:00 Connie C. Schmitz -- CBPH Cluster Evaluation Coordinator; University of Minnesota Research Associate, Center for Urban and Regional Affairs.

- Introductions
- Background on the CBPH Cluster Evaluation (CE)
- Overview of the Networking Conference agenda
- Questions and discussion

Wednesday

Breakfast is on your own. At 8:00, take the hotel shuttle to the Hubert H. Humphrey Center, University of Minnesota campus (west bank). Meet in the Stassen Room, second floor.

8:15 Consortium Reports -- moderated by Diane Morehouse, CE team member; Consultant and President of *Quality Evaluation and Development* (QED)

- A representative from each consortium will be asked to briefly describe where their group is "at" in terms of evaluation; what they hope to accomplish, how the work is proceeding, what questions or problems they have at this point.

9:30 Summary of Consortium Reports -- Diane Morehouse

- Summary of consortium evaluators' questions and concerns. Discussion and clarification of concerns. Responses by the CE team and WKKF.

BREAK

10:30 Review of Cluster Evaluation Strategies -- The Cluster Evaluation Team

- Documentation *(Carlson)*
- Site Visits *(Johnson)*
- Videotape Project *(Schmitz)*
- Follow-Up Survey of Leadership and Model Development participants *(Schmitz)*
- Devising a Template of Common Indicators *(Morehouse)*
- Questions and feedback from participants, guests, and the Foundation.

12:00 LUNCH *in the Humphrey Center private dining room, lower level*

After lunch, please reassemble in the Humphrey Center Commons Room, second floor

1:30 Guiding Evaluation Questions for the Cluster Evaluation -- Connie C. Schmitz

- What do we want to learn about the CBPH initiative?
- Small group exercise

BREAK

3:30 "Community Empowerment: An Intriguing Process." -- Carol McGee Johnson, CE team member, Consultant in program development/ evaluation, citizen politics and diversity.

- An interactive discussion on how communities develop capacity. How empowerment can be recognized, observed, assessed.
- Additional handouts and materials.

Dinner is on your own. Check your folder for restaurant suggestions.

Thursday

Breakfast is on your own. At 8:00, meet in the Radisson Hotel, Humphrey Room

8:15 "FORECAST: An Approach to Evaluating the Progress of Coalitions" -- Abe Wandersman, Professor of Psychology, University of South Carolina; Evaluator of CSAP Community Partnerships; Consultant to the CE team.

- Lessons learned from CSAP evaluations.
- A suggested evaluation model; handouts, materials, further reading.
- Questions and discussion.

BREAK

10:15 Participants' Work Session

Participants can use this time to work alone or with each other on their consortium evaluations. Or, they may wish to share their ideas for consortium evaluation with others to gain feedback, discuss common strategies or problems.

12:00 LUNCH *at the Radisson Hotel, Room*

1:30 Reflections and Questions. -- Mary Odell Butler, Research Analyst, Battelle Memorial Institute; Coordinator, Evaluation of the Kaiser Foundation Community Health Promotion Grants Program (Southern Strategy); external advisor to the CE team.

- Evaluation lessons learned from the Kaiser Initiative.
- Critique: Questions for consortium and CE evaluators and WKKF to think about.

2:15 Panel Discussion -- moderated by Mary Odell Butler
(Panel consists of Bruce, Schmitz, Morehouse, Johnson, Wandersman.)

- Discussion of Butler questions. Interactive discussion between panel, participants, and WKKF.

3:15 Wrap-up -- moderated by Connie C. Schmitz

- Next steps for cluster evaluators and consortium evaluators
- Conference Evaluation Form
- Future meetings

4:00 CLOSE

Conference Evaluation Form

CBPH Evaluation Networking Conference: Year 1

Please indicate the extent to which you feel clearer than before the Conference about the following: N = 15/16	(Frequency of Responses) **Still not Clear**		**Somewhat Clearer**		**Much Clearer**
1. The purpose of CBPH consortium evaluation	1	2	5	6	1
2. The purpose of CBPH cluster evaluation	2	2	7	2	2
3. Evaluation activities of the CE team	3	1	7	2	2
4. What you want to do next with your consortium evaluation -- ways to proceed	1	0	8	3	3

5. What questions or concerns do you have (if any) about your consortium's evaluation?

* Should there be an external or internal evaluation?

* Extent to which driven by Governance [Council]?
  Involvement of community?
  Common data set?
  Methods?

* What will be evaluated?

* Disagreements among members of the consortium as to the importance of evaluation relative to other activities, in light of limited resources.

* Still need to do alot of work on prioritizing what will be evaluated, how to operationalize and measure, and strategies for conducting the evaluation.

* Many. Unit(s) of analysis, what to assess, how to go about it, what kinds of issues will arise in managing different agendas and levels of power. [I] suspect many of these will not be answered until I am in the field and begin to watch things unfold.

* I am concerned about Governance Board buy-in as to the amount of work they will have to do.

* Concerns: you listed them in sessions (Focus, Resources)
  Question: will the Cluster Evaluation be coordinated with consortium steps? Will consortiums be able to use and learn from each other?

* Just getting further verification and input from the rest of the consortium.

* Concerns in re: individual and partners' agendas that may not be relevant to the overall empowerment of communities, particularly the academic institutions.

n = 10/15

6. What questions or concerns do you have (if any) about the cluster evaluation??

* How can the work on the "indicators" best be coordinated with the local evaluation?

* I know it's almost impossible, but for me a bit more unilateral decisions by you would be welcome.

* The team does not understand what is unique, i.e., the essential difference, between other coalition models to health promotion and the CBPH Initiative. This will cause a serious missed opportunity over the next four years.

* How will consortium be evaluated? - indicators?

* Are you sure of Kellogg's objectives? You can evaluate our process - but . . . ?

* What kinds of data will you be collecting? How will CE evaluation data interface with consortium data?

* As noted above, still unclear about Cluster Evaluation's role. Realize the CE is still in conceptualization stage, but wonder when more clarification may come.

* Desire that the two complement each other and minimize duplicative efforts.

* Still not clear exactly what the CE will be looking at and how this will interface with each site consortium evaluation.

* I am concerned about a perceived expectation that I be more involved wih the cluster evaluation than simply the sharing the data, process and experiences.

* See above. Who is the audience?

* Lack of clarity in questions and indicators (utility)

n = 12/15

To help us plan next year's agenda, indicate which type(s) of sessions you would value the most by rating the importance of each.

		(Frequency of Responses)				
		Not at all Important		**Somewhat Important**		**Very Important**
7.	Sharing plans, talking over problems with other consortia project directors & evaluators	0	0	2	3	10
8.	Receiving feedback from the CE team	0	2	3	4	6
9.	Learning from external resource experts	4	4	2	3	2
10.	Dialoguing with the Foundation about the CBPH	0	0	4	3	8

What topics or issues do you think should be addressed in the next Networking Conference with project directors, evaluators, and Foundation staff? *(Yes, we know the conference is a year away and so it's hard to say, but . . . we'll ask the question anyway)*

* How can leaveraging be facilitated?
  How can coalition maintencance be facilitated?

* Having come on board with a somewhat "short notice" to this meeting, and as Project Coordinator of our project, I just want to say that it has been exciting and complex. I enjoyed the communication, (in that I mean) the one-on-one sharing with project directors and evaluators. I came to this Kellogg Networking Conference with a somewhat clearer understanding of what the Foundation and the Cluster Evaluation team hoped to accomplish.

* Evaluation Priorities. Critical Empowerment Indicators.

* Evaluation training for non-evaluators. Methodological cutting edges. Dissemination strategies.

* Results from first year. More clarity on the different levels of analysis (e.g., units of observation) and variables being "shared" by project and cluster evaluations.

* Let me think about it, and provide some suggestions later.

* Progress reports.

* Discuss strategies used, problems, accomplishments, lessons learned. Share materials developed.

* Really is difficult to tell now. But we should have clearer idea next year. What might be helpful would be to send pre-conference questionnaire asking the above question. Also, might be helpful ti include other issues/questions in that pre-conference mailing - things that can be handled at "first look" by mail so that when we arrive at conference, we can have a headstart on issues. There was so much to address and so little time that some pre-conference "whittling down" may have helped.

* Reconfigurations of consortia operations and programmatic components that have taken place as a result of evaluation process.
  Reconfigurations of consortia operations and programmatic components as a result of external factors (both positive, e.g., additional FOG, leveraging, etc., and negative, e.g., environmental factors).

* Sorry, don't know other than to share where we all are and to have opportunity to problem solve on issues that may be of concern.

* Problems that we're having should be shared.

* What was learned? Successes! Bring tools of evaluation. Vision of plan for next few years. Rethink format: more interactive sessions between consortiums. Structure outline of topic but do not structure discussion.

* Where people are. Frameworks and outcome measures. Lessons learned in planning, implementation, and evaluation. Foundation's view. Health Reform and potentials,

opportunities, which these consortia have for assuring community input. Think through who and how many may want to have CBPH take advantage.

* Multi-cultural value systems. Affective policy. Expansion of consortium partners. Sustainability. Training opportunities. Update on health care reform.

n = 15/15

Any other additional comments?

* Communicate to each consortia the suggested mix of participants for the Ann Arbor meeting.

* I like small groups and would encourage keeping groups small and using break-outs.

* (In regard to using external resource experts): I think the history of the CBPH has proven that external persons miss the target. No one has done what we are attempting.
  Need to use the evaluation-with-empowerment agenda expertie that exists among groups.

* Helpful meeting.

* The feedback from Mary Odell Butler was very constructive - both in sharing her own experience with a similar process and her observations about where we need to work further on our "elephants." Bring her back next time!
  [In regard to external resource experts]: Not sure yet - it will depend where we are in a year.

* Look at the energy levels of this session to build next conference [e.g., high for empowerment discussion, concrete topics such as topic areas (focus and self-evaluation), etc.]. Consider use of "experts" on a more one-one-one working session style?

* Need more passion! I see the need for more varied format, with more participatory working groups, panel discussion of attendees on issues like diversity, lobbying, policy making at the local level.

Kellogg Videotape Workshop
July 15-18, 1993
Minneapolis, MN

Thursday July 15

6:30 pm Dinner Buffet -- Holiday Inn Board Room
7:30 pm Welcome and opening comments, *Connie Schmitz and Rich Reardon*

Friday July 16

8:30 am Orientation at **Rarig Center Conference Room 540F**
Rich Reardon and Juli Manser
- welcome, housekeeping, mock meeting shoot
- workshop agenda
- community resources and support
- references for further information and study

10:30 am Break

- video basics
- shot composition basics
- camcorder introduction and equipment inventory
- battery information and microphone orientation
- what NOT to use on the camcorder
- videotape stock and tape care

12:00 pm Lunch

1:00 pm Small Group Activities (see description on next page)

5:00 pm Wrap Up

6:30 pm Dinner at the Hey City Cafe: West Bank, Seven Corners (333-9202)

Saturday July 17

8:30 am Small Group Activities (see description on next page)

12:00 pm Lunch

1:00 pm Small Group Activities (see description on next page)

5:00 pm Wrap Up

After 5:00 Dinner on your own

Sunday July 18

No workshop activities. Participants depart according to own plans.

SMALL GROUP ACTIVITIES

Participants will spend Friday afternoon and all day Saturday getting hands-on experience in small group activities. Each group will have between 4-5 people. When filming, groups will be further divided so pairs of people from the same consortium will be working one-on-one with a trainer.

	Group 1	**Group 2**	**Group 3**
Fri 7/16 PM	Editing	Shooting	Producing
Sat 7/17 AM	Producing	Editing	Shooting
Sat 7/17 PM	Shooting	Producing	Editing

PRODUCING

Rarig Conference Room 540F with Rich Reardon
- what is to be visually communicated? how?
- "out-producing" reality
- location scouting, or "the distraction that wasn't"
- directing techniques
- working with non-professionals
- other considerations: video releases, copyright, etc.

SHOOTING

Various West Bank Campus Locations with Juli Manser and Elleni Fellows
- tripod use
- shot selection
- camera techniques: zoom, pan, tilt, hand/shoulder held
- microphone techniques
- lighting on the cheap
- shooting for the editor

EDITING

Rarig Center Studio A with Karla Rydrych and Kevin O' Brien
- what helps the long distance editor
- what can and cannot be fixed in the editing room
- the "grammar" of video editing
- the importance of audio elements

Calendar For Year Two
Cluster Evaluation Activities
1993-1994

'93- '94	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
WKKF Meeting	9/23 BC											
Meeting in Atlanta on QOL instrument		10/8										
Site Visits					NC 1/10 GA 1/10	MD 2/7 CAL 2/14	MI 3/14 WA 3/21					
Project Directors Meeting					?							
Data Collection for Individual Data Base	9/20	10/31					3/18	4/30				
Evaluation Networking Conference			?	?					?			
CBPH Annual Meeting										?		
Develop goal agreement inventory		*	*	*								
Videotaping	*	*	*	*	*	*	*	*	*	*	*	*
Develop costs & Benefits Survey								?	?	?		

Themes from Year 1 Site Visits

1992-1993

Introduction

The purpose of this synthesis is to flesh out the major recurring themes found during initial site visits to seven CBPH consortia during the first year of Initiative operation. Seven themes have been identified that seemed to be common to all consortia the first year. Therefore, our intent is to capture, in a general sense, knowledge of those themes and their implications for future operation of the Initiative.

1. Diversity of Stakeholders

Within the constituent groups of community, public health practice and academe (the partnerships mandated by WKKF) CBPH consortia exhibit a wide range of stakeholders, from narrow to broad bases of constituents. If we characterize CBPH consortia as "arranged marriages," a basic question to consider is to what extent the consortia have the "right partners" at the table, given the marriage of community, academe and public health practice.

In the community category, some consortia are working with formal community-based organizations (CBOs), while others are working directly with citizens and communities in the process of organizing because of the CBPH (See Table 1). Community partners include rural, urban, suburban communities, and range from single ethnic communities to multicultural communities.

These factors influence consortia development and cluster evaluation practice in various ways. Utilizing the arranged marriage metaphor, we may find that citizens in individual communities feel more affinity with CBOs that represent them directly than with members of CBPH consortia who require their input and involvement, thus affecting the development of shared mission within individual consortia. If community is defined broadly, as inclusive of CBOs and citizens, consortia that tap into organized community infrastructures may realize greater results than those who do not. The cluster evaluation responded to the distinction between community and CBOs by building an evaluation blueprint that includes both, with different evaluation questions, outcomes and indicators for each.

In the academic category, various academic partners currently make up the academic component of the CBPH. However, the addition of public health practice and community partners to academic teams (which we saw little of the first year) poses a big challenge for academia, and ultimately CBPH consortia. The public health practice category is larger than simply public health departments. How the community input and participation is integrated into public health practice remains to be seen.

These "arranged marriages" within individual partnerships, as well as within the consortia as a whole, raise questions of diversity and the complexity of engaging the right partners to do the work of the Initiative. It is an experimental process that should yield interesting results over the next three years.

2. Size and Complexity of Consortia

The size and complexity of the CBPH consortia is varied. It includes considerations of geographic spread and number of sites, number of partners and fluidity of membership. A basic question to consider is what configuration of geography, partners, sites and membership increases the likelihood of successful consortia operation and stability?

Geographically, the CBPH consortia range from a single geographic site to multi-geographic sites. Within the three constituent categories of academe, community and public health practice, some CBPH consortia have relatively few partners and members, while others have many intricate partnerships and members. We observed that communication within consortia that are spread across geographic sites is more difficult, as is communication within consortia that have particularly high memberships.

Of the CBPH consortia observed during the first year, three consortia's membership seemed fixed and stable, while four consortia's memberships were expanding; new partners were being added and brought on board who had little knowledge of the history and goals of the consortia, thus adding to the size, complexity and potential communication problems within the consortia.

We don't know the optimum point of stabilization for consortia, given size and complexity, although we tend to think a single site and stable number of partners increases the likelihood of success.

3. Internal Structure (Governance)

The size and complexity of consortia gives some indication of the challenges individual governance structures face. One basic question to consider is the extent to which decision-making within the consortium is inclusive of a broad representation of stakeholders.

During the first year, all consortia, with the exception of one, were in the process of developing a central governing board empowered to make major decisions about project design, goals and implementation, personnel and staff, allocation of resources, as well as compile official progress reports.

Representation on governing boards varied across the Initiative. Various facets of leadership were observed, from who headed governing boards and/or took the lead as fiscal agents to which partners took on a general leadership role of the consortia. In general, the driving forces within consortia tended to be community or academe, rather than public health practice.

Across the consortia, a consensus model seems to be the predominant method of decision-making, with the majority of consortia formally structured (by-laws, memos of agreement, specified membership). We observed tension between the broad representation and a consensus models of decision-making (one group has been stymied by its consensus model and unable to move forward) as well as between the need for some hierarchy to facilitate decision-making and action versus lack of hierarchy.

Some consortia learned that everyone cannot be involved in every decision, which raises the question of how to delegate decision-making capacity to some governing board members on certain issues and still maintain the integrity of the whole.

4. Shared Mission, Goals and Work Strategies

Essentially, only one consortium seemed to have a broadly shared vision, to create a community health academy, a vision to which all members seemed highly committed. Another consortium articulated a mission of "changing public health practice and education by connecting communities to health departments and universities," but it was clear this mission had not yet been bought into by all consortium members. Members of another consortium seemed to agree their primary goal is to "create and sustain new relationships," that would heal a historic breach between the university and the target community and have the potential to change health status indicators in the target community.

Three consortia had no shared mission; separate agendas within the consortia, while commendable, were not connected by a common vision or agenda. Another consortium articulated a general commitment to "get the job done," but seem stymied by perceived budgetary obstacles.

Most of the CBPH consortia were poised to begin work at the time of the initial site visits. By and large, work strategies have been developed within the consortia, relative to the goals of various proposals. They generally included: revision of course content in schools of public health; delivery of health education and services in communities; and increasing the capacity of the health department to collaborate with communities around public health issues identified by the community. As of the initial site visit, most consortia had not yet implemented strategies to address those goals to any significant degree, although across the consortia there was evidence of curriculum revision and new course development underway. The curriculum and new course activity did not reflect community and health department input to any significant degree the first year.

In general, the consortia have been slow to move into an active, goal-oriented work phase because various administrative problems have gotten in the way, such as difficulties bringing project directors and evaluators on board, resolution of budget issues, and for some, taking the time needed to work with communities to increase their readiness to take on specific work projects. Most consortia focused their first year's work activities around "organizational development, and "administrative preparation," including organization of their governance boards and development of workplans. Now it is time to move ahead. It will be interesting to see which consortia make smooth transitions to health-related work activities.

In general, more goal-related work activity was observed amongst academic partners than public health practice or community partners. This is not surprising because the academic partners know one another, have generally worked together in the past, and have a shared mission. The extent to which consortia develop a shared mission and goals is critical to the forward movement of the *whole consortia* , not just one part of it.

We hope to address the problem of unclear, conflicting and not clearly shared goals next year by having members of each consortia complete a "Goal Agreement Inventory." One final concern is the absence of any goals to influence policy across the Initiative, especially since the foundation has emphasized policy implications throughout the first year. This will need to be addressed, to help consortia focus their work activities accordingly.

5. Collaboration

The analogy of arranged marriages is particularly appropriate when considering CBPH consortia's first year of collaboration. In an arranged marriage, it is usually clear what each

party brings to the union; mutual benefit is the reason for the joining. In the case of the CBPH consortia, it was not always clear during the first year what each partner brought "to the table," so to speak, making effective collaboration more difficult.

Some consortia's members had collaborative relationships that preceded the CBPH. Some of those relationships were characterized, however, as "dysfunctional" or "too established." Others reported a history of friendly group relations, but wanting to increase the productivity of those relationships and/or broaden the collaboration to include other already established health initiatives.

In some other consortia, collaborative relationships were essentially new, without any history of previous collaboration. Members did not know one another and had not worked together before. The consortia were characterized by divergent and conflicting viewpoints. In these cases, group dynamics need to be addressed, possibly professionally, to develop the trust and cohesion needed to build effective collaborative relationships. Models of conflict resolution were not observed.

It remains to be seen how the presence or absence of a shared mission may impact the capacity of consortia to collaborate toward common ends. People talked a lot about collaboration, but we suspect it was happening much less than it was talked about. Most collaboration to date has been around organizational development. With the implementation of specific work strategies, the need to define roles and responsibilities may force closer collaboration, or drive members apart if the mission and goals are still unclear.

The purpose of the CBPH arranged marriage is to promote the academe-public health practice-community collaboration in schools of public health, target communities and public health departments. The success of the Initiative, this "arranged marriage," hinges on the extent to which this happens.

6. Budgetary Constraints

A major recurring theme across the Initiative at the time of the initial site visit was one of reaction to budgetary constraints because of smaller grant awards from the Foundation. While one consortium dealt with the reality of budget cuts philosophically, most of the consortia attributed slow implementation of work strategies to budget cuts. At a minimum, questions of budget constraints have impacted the entire Initiative during the first year in various ways.

One consortia decided to delay their official start for six months, given budget considerations. Another consortia allocated the majority of its funds to the community, which placed constraints on the institutional partners to provide some of the services the community expected. Across the consortia, plans for evaluation were being pared down and cut because of funding considerations, according to consortium members.

The process of allocation of resources was not officially underway at the time of our official site visits, because many of the consortia's work activities had not begun. Governance boards were still reviewing budgets and making changes. Some community representatives questioned whether communities had the same access as universities and health departments to project resources, while in one case, academic institutions questioned if they would be able to meet their commitments when communities received the majority of the funds. Clearly, conflicts around budgets were a major obstacle the first year.

The real question most consortia grappled with was whether or not they would be able to meet their work commitments and goals, given the decrease in funding. Concerns were expressed about the adequacy of funds for projected activities. As the Initiative moves into its second year, it will be important to assess if work strategies and goals are being adjusted to reflect budget considerations. Across the Initiative, ambitions tended to exceed funds. Consortia may find they need more partners with access to dollars, resources and additional funding sources.

Conclusion

While these recurring themes are important for consortia development, they have major implications for the cluster evaluation as well. Our responsibility is to look at the Initiative as a whole, its direction as well as its general impact, in communities, schools of public health and public health practice. While these themes indicate cause for some concern, it is important to place them in an overall context of *development and experience.* There are very few books written about how to do this kind of work well, so the CBPH consortia are essentially "learning as they go." The lessons they learn can help create the knowledge base needed to address major issues of change and redistribution of power in American society. Our role, as cluster evaluators, is to capture the changes in a way that others can see them, learn from them and be inspired to do business differently.